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Once thought to be rare, Obsessive Compulsive Disorder (OCD) is currently recognized as the fourth most common psychiatric disorder among adults, following only phobias, substance abuse and major depression. In fact, it has been estimated that 1 in 50 adults in the United States (U.S.) currently has OCD.

Epidemiology

According to the American Psychiatric Association, the lifetime prevalence rate of OCD is estimated at 2.5% in the U.S. Recently, researchers and practitioners have found that OCD is much more common among children and adolescents than once was thought. Epidemiological data regarding OCD in youth is sparse, but prevalence estimates range from 1 to 3.6% for children and adolescents. This means approximately 1 in 200 children and adolescents, or three or four children in an average elementary school and as many as 20 in most high schools, have OCD.

Clinical cases of OCD have been diagnosed in children as young as 3 years old. Researchers posit that prevalence figures may underrepresent OCD's occurrence in youth populations. Prominent researchers and practitioners postulate that the disorder often goes unrecognized and untreated due to possible secretiveness about symptoms or a lack of awareness about the disorder and the availability of treatment. Others note parents and general practitioners may fail to recognize a child's "strange behavior" as symptomatic of OCD, attributing it instead to childhood phases. As a result, children and adolescents with OCD may be unrecognized and untreated.

OCD differs from the developmentally appropriate affinity for routine and repetition displayed by most children. It is common for children to like things "just so" or to demand the same bedtime ritual night after night. OCD behaviors can be differentiated from these developmentally appropriate behaviors by their timing, nature, and intensity. Developmentally appropriate OCD behaviors tend to emerge early, are rare among adolescents, and are widespread. On the other hand, diagnosable OCD behaviors emerge later, hinder rather than enhance the child's development, and appear bizarre to adults and other children. Further, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) of the American Psychiatric Association differentiates obsessions from simple worries about actual problems. It also requires that at some point in the illness, adults with OCD must recognize that the obsessions of compulsions are unreasonable and ex-

cessive before a diagnosis of OCD can be made. This component of insight is waived for children and adolescents.

While the average age of onset of OCD is the early 20s, adolescent onset is reported by one third to one half of adult patients. Research indicates as many as 80% of adults with OCD experienced childhood or adolescent onset. Indeed, the modal age of onset for males is between ages 6 and 15, while the modal age of onset for females is between ages 20 and 29. Boys are more likely to experience onset of OCD prior to puberty, while girls with childhood OCD are more likely to report onset during adolescence. Although epidemiological data indicate no differences in prevalence related to ethnicity or geographic location, in clinical samples, OCD is more common among White children than African American children.

Although the causes of OCD are unclear, most experts concur that it is a neurobehavioral disorder in which anomalies in the brain lead to problems in processing information. OCD has been linked to a lack of serotonin, a chemical messenger in the brain that carries information from one nerve cell to the next. Further, using positron emission tomography (PET) scans, it has been determined that areas of the brain including the basal ganglia, caudate nucleus and the orbital frontal regions are overactive in people with OCD. As a result, people with OCD report feeling as though their brain gets "stuck" or locked in a thought or worry and cannot move on. Practitioners stress that OCD is a biological disorder, not simply a behavioral disorder.

Diagnosis

According to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), OCD involves anxiety caused by intrusive, unwanted thoughts or images (obsessions) and/or the use of repetitious intentional behaviors or mental acts (compulsions) to reduce the anxiety. The DSM-IV states that to be diagnosed, the symptoms of OCD must result in significant impairment in the individual's academiclvocational and social functioning stemming either from the amount of time demanded by ritualistic compulsions (at least one hour per day) or from psychological distress.

Among the most common obsessions experienced by adults and youth with OCD are fear of contamination, fear of harm to oneself and to others, and a desire for symmetry or exactness. Obsessions involve a combination of unwanted, intrusive thoughts, urges or images and corresponding negative feelings like fear or anxiety. Compulsions are repetitive behaviors that may be employed in an effort to reduce the negative feelings associated with obsessions. They include such behaviors or mental acts as excessive washing and cleaning, checking, counting, repeating routines, touching, and straightening. Among children with OCD, washing and checking rituals are particularly common. In an unfortunate cycle, compulsions are reinforced when they temporarily reduce anxiety. This, in turn, strengthens the urge to perform the compulsion and adds fuel to the obsession. Symptoms of OCD tend to both co-occur and to change over time, so the same individual with OCD will likely experience many different symptoms over time and these symptoms will wax and wane depending on environmental factors (i.e., stress).

Treatment

While treatment for OCD in adults has been well-researched, the literature base regarding its treatment among youth is more limited. What is known, though, is that OCD is treatable. Adult interventions utilizing behavioral, cognitive behavioral and psychopharmacological strategies have proven effective. In 1997 the Expert Consensus Treatment Guidelines for Obsessive Compulsive Disorder were developed after surveying 69 experts on OCD. These guide-

lines provide treatment recommendations for OCD in children, adolescents and adults. Overall, the experts recommended using Cognitive Behavioral Therapy (CBT) alone or in combination with psychotropic medication in the treatment of OCD.

As noted above, CBT is widely regarded as the psychotherapeutic treatment of choice for OCD. This treatment generally consists of a series of 12-20 structured therapy sessions involving assessment and progress monitoring, therapist assisted exposure and response prevention (E/RP), and homework assignments to be completed between sessions. Exposure involves reducing the anxiety associated with particular obsessions through repeated contact with the object of fear. For example, people with obsessions about germs are assisted by the therapist in gradually increasing their contact with "germy" objects (i.e. handling money) until the anxiety is eliminated. For maximum benefit, exposure (E) is combined with response prevention (RP), in which the person refrains from performing compulsions or rituals to reduce anxiety brought on by exposure. In the previous example, the person with obsessions about germs would first handle money, then refrain from hand washing. Such protocols have found well documented empirical support in adults and youth over the last 25 years with patients reporting a 50-80% reduction in OCD symptoms.

Psychopharmacological treatment employing antidepressants, particularly the Tricyclic Antidepressant (TCA) Clomipramine, and Selective Serotonin Reuptake Inhibitors (SSRI's) have also enjoyed support in the literature. These medications work by increasing the levels of neurotransmitters in the brain. Clomipramine was indicated for the treatment of OCD by the FDA in 1989. It was soon followed by the SSRI's, Fluoxetine, Citalopram, Sertraline, Paroxetine and Fluvoxamine.

Treatment for OCD must be individualized. There is no single approach that works best for everyone although the consensus is that CBT alone, or in combination with an SSRI is likely to have the best effect. There is evidence that brain functioning can return to near normal with either CBT or medication therapy. Research regarding the individual and combined efficacy of treatment methods for OCD is ongoing.

Suggested Reading

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, D.C.: APA.

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Suggested Resources

Obsessive-Compulsive Foundation (OCF)—http:// www.ocfoundation.org/. This website provides information and sponsors research on the nature and treatment of OCD. Additionally, the OCF sponsors support groups around the country and provides referrals for treatment providers.

The Association for Behavioral and Cognitive Therapies—http://www.abct.org/. This interdisciplinary professional organization is concerned with the application of behavioral and cognitive sciences to understanding human behavior, developing interventions to improve the human condition and promote the appropriate use of these interventions. The website provides resources and therapist referrals.